School Health and Related Services (SHARS)

2020 SHARS Cost Report Training

Presented by HHSC Provider Finance

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Agenda

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  - Allowable costs vs. non-allowable costs
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Housekeeping Items

- Webinar audio options
  - Phone Call
    - Must use the telephone number, access code and audio pin found on the right hand side of screen
  - Computer Audio
- For all technical difficulties contact Webinar Support at 1-800-263-6317
- Training duration
- Breaks
- Must be present and attentive during entire training presentation to obtain training credit
- Email name of participants if sharing a computer

Housekeeping Items

- GoToMeeting Chat Function
- GoToMeeting Raise Hand Feature
- Polling questions
- Email questions to ProviderFinanceSHARS@hhs.texas.gov

or call the SHARS Help Line at (512) 730-7400

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SHARS Program Overview

Medicaid services provided by school districts in Texas to Medicaid-eligible students are known as School Health and Related Services (SHARS). The oversight of SHARS is a collaborative effort between the Texas Education Agency (TEA) and the Health and Human Services Commission (HHSC). SHARS allows local school districts, including public charter schools, to obtain Medicaid reimbursement for certain health-related services prescribed by a health professional and documented in a student's Individualized Education Program (IEP).

SHARS Program Overview

SHARS reimbursement is provided for students who meet *all* of the following requirements:

- Are 20 years of age or younger and eligible for Medicaid
- Meet eligibility requirements for special education described in the Individuals with Disabilities Education Act (IDEA)
- Have IEPs that prescribe the needed services

The Individuals with Disabilities Education Act (IDEA) is a United States federal law that governs how states and public agencies provide special education, and related services to children with disabilities. It addresses the educational needs of children with disabilities in cases that involve 14 specified categories of disability.

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SHARS Program Overview

In order to receive and retain federal reimbursement for Texas Medicaid, as a provider of medical services for SHARS, an ISD must:

- Be enrolled and approved as an active provider with Texas Medicaid & Healthcare Partnership (TMHP);
- Ensure all SHARS services are provided by approved/qualified providers as indicated in the Texas Medicaid Provider Procedures Manual (TMPPM);
- Bill for and clearly document allowable Medicaid services as they are delivered;
- Abide by HHSC rules and regulations and meet the TEA standards for the delivery of SHARS;
- Meet all eligibility requirements and participate in the Random Moment Time Study (RMTS);
- Submit an annual SHARS Cost Report; and
- Comply with all state and federal audits.

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SHARS Program Overview

Services covered by SHARS include:

- Audiology, including evaluations and therapy sessions;
- Counseling;
- Nursing Services, including routine medication administration services;
- Occupational Therapy, including evaluations and therapy sessions;
- Personal Care Services *;
- Physical Therapy, including evaluations and therapy sessions;
- Physician Services;
- Psychological Services, including evaluations and therapy sessions;
- Speech Therapy, including evaluations and therapy sessions; and
- **Specialized Transportation.**

*** PCS providers are required to carefully review and document PCS services (TMPPM 3.3.6)**

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SHARS Billing

- Per TAC Rule §354.1342(8), districts must bill for each cost category for which it intends to seek reimbursement through the annual cost report.
- Districts are required to bill for these services through the TMHP claim system.
- The TMHP claim system provides for prompt eligibility verification, identifies duplicate claim filings, creates a complete audit trail from service to claim, and documents payment data necessary for the Surveillance and Utilization Review (SUR) system.
- Failure to bill for services in accordance with the TMPPM and the Texas Administrative Code (TAC) may impact a school district's Medicaid funding and subsequent reimbursements.
- *All* associated costs in the cost category will also be disallowed if the cost category is not billed for at least once during the cost report period.

SHARS Billing

- Refer to the TMPPM Volume 1: Section 3 – TMHP Electronic Data Interchange (EDI) for information on electronic claims submissions.
- Refer to the TMPPM Volume 1: Section 6 – Claims Filing for general information on claims filing protocol. Claims must be submitted within 365 days from the date of service or no later than 95 days after the end of the Federal Fiscal Year (January 3rd), whichever comes first.
- Payment denial codes are applied to the Texas Provider Identifiers (TPI) that have had no claim activity for a period of 24 months or more. Once a payment denial code has been applied to a TPI, it will be considered inactive and will not be able to be used to submit claims.
- To have the payment denial code removed from a TPI, providers must submit a completed application for the state health-care program in which they wish to enroll and the application must be approved by TMHP. The information on the application must match the information currently on the provider's file for the payment denial code to be removed.

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SHARS Billing

Parental Consent

TEA and IDEA require one-time written consent from the parent and written notification before accessing a child's or the parent's public benefits or insurance for the first time and prior to obtaining the one-time parental consent and annually thereafter. All schools participating in SHARS must be in compliance with 34 CFR §300.154 and 34 CFR § 300.300.

TEA SHARS Website:

https://tea.texas.gov/index2.aspx?id=25769817836

*Note: A lack of parental consent does **NOT** equal consent. Consent must be given in writing for services to be provided.*

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Parental Consent

It is the district's responsibility to maintain documentation verifying parental notice was provided and consent was obtained. If the district is selected for a desk review or an audit, it may be asked to produce documentation showing that all parental notice/consent requirements were fulfilled.

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SHARS Billing

(Claims Billing) Appeal Process

(TMPPM) Children's Services Handbook, Volume 2: Section 3.5.1.1 Appealing Denied SHARS Claims

- SHARS providers that appeal claims denied for exceeding benefit limitations must submit documentation of medical necessity with the appeal. Documentation submitted with an appeal must include the pages from the IEP and Admission, Review, & Dismissal (ARD) documents that show the authorization of the services, including the specified frequency and duration and the details of the need for additional time or the reasons for exceeding the benefit limitations. Each page of the documentation must list the client's name and Medicaid number.

(TMPPM) Volume 1: Section 6.1.4.4 Appeal Time Limits

- All appeals of denied claims and requests for adjustments on paid claims must be received by TMHP within 120 days from the date of disposition, the date of the Remittance and Status (R&S) Report on which that claim appears. If the 120-day appeal deadline falls on a weekend or holiday, the deadline will be extended to the next business day.
    - Refer to: Subsection 6.1.1.2, "Claim Filing Instructions" in this section

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SHARS Billing

Remittance & Status (R&S) Reports

- TMHP provides weekly R&S Reports to give providers detailed information about the status of claims submitted to TMHP.
- The R&S Report also identifies account receivables established as a result of inappropriate payment. These receivables are recouped from claim submissions.
- If no claim activity or outstanding account receivables exist during the cycle week, a provider will not receive an R&S Report.
- The R&S reflects claim payments processed during the period stated on the report regardless of the SHARS dates of service.
- **Providers are responsible for reconciling their records to their R&S reports to determine payments and denials received.**

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SHARS Billing

Certification of Funds (COF) Statement

- The purpose of the Certification of Funds (COF) statement is to verify that the school district incurred costs on the dates of service that were funded from state or local funds in an amount equal to, or greater than, the combined total of its interim rates times the paid units of service.
- SHARS providers are required to certify the amount reimbursed during the previous federal fiscal quarter of each quarter of the federal fiscal year (October 1 through September 30).
- While the payments were received the previous federal fiscal quarter, the actual dates of service could have been many months prior. Therefore, the certification of public expenditures is for the dates of service and not the dates of payment.
- **NOTE: In response to COVID-19 and associated school closures, TMHP is sending the COF letter through email to SHARS providers in addition to the current mailed letter. The most updated notice can be found on TMHP's website.** https://www.tmhp.com/news/2020-11-20-second-update-certification-funds-letter-be-emailed-shars-providers

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SHARS Billing

Certification of Funds (COF) Statement

- The COF statement must be:
  - Signed by the business officer or other financial representative who is responsible for signing other documents that are subject to audit
  - Notarized
  - Returned to TMHP within 25 calendar days of the date printed on the letter.

Failure to meet the COF requirement may result in recoupment of funds or the placement of a vendor hold on a provider's payments until the signed COF statement is received by TMHP. Providers should call the TMHP Contact Center at 1-800-925-9126 if they do not receive their COF statement within a week of the end of the federal fiscal quarter.

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SHARS Cost Report

- Centers for Medicare & Medicaid Services (CMS) requires annual cost reporting, cost reconciliation, and cost settlement processes for all Medicaid SHARS services delivered by school districts.
- The primary purpose of the cost report is to document the provider's costs for delivering SHARS services to reconcile the provider's interim payments received for SHARS services with its actual total Medicaid allowable costs.
- In accordance with Title 1 of the Texas Administrative Code, Part 15, Chapter 355, SubChapter J, Division 23, Rule 8443, each SHARS provider must complete an annual cost report for all SHARS services delivered during the previous federal fiscal year covering October 1 through September 30.
- Each SHARS provider who is a member of a cooperative or shared services arrangement must submit a separate SHARS cost report and have a district-specific RMTS Participant List (PL).
- All annual SHARS cost reports that are filed are subject to audit and/or desk review by HHSC or its designee.
- Failure to file a complete and acceptable cost report by the cost report due date in accordance with all instructions and rules will result in recoupment of all interim payments received during the cost report year.

SHARS Cost Report

Important Dates

- **Due to the unprecedented impact of COVID-19 on schools, CMS is diligently working on approving special Time Study and FMAP percentages. As a result, 2020 cost reports are not available to be completed in STAIRS at this time. Please check your email frequently for a notice with updated OPEN/CLOSE cost report dates.**
- Cost Report Training for SHARS Cost Report (Mandatory)
  - **January, February, and March**
- Federal Fiscal Year (SHARS Cost Report Period)
  - **October 1 – September 30**
- Cost Report Due Date (Strictly Enforced)
  - **April 1**
- Cost Report Corrections Due Date (Strictly Enforced)
  - 60 days after cost report due date
- Cost Report Settlement
  - **February/March**
- First Quarter PL Submission Deadline
  - **September 15**

SHARS Cost Report

All SHARS cost reports are built, maintained, and submitted through the State of Texas Automated Information Reporting System (STAIRS).

STAIRS* is a web-based system provided at no charge by the HHSC Provider Finance Department and its contractor, Fairbanks LLC.

https://cr.fairbanksllc

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SHARS Cost Report

Standards for an Acceptable Cost Report

Each cost report *must*:

- be completed in accordance with the cost report instructions and reimbursement methodology rules;
- be completed for the correct cost-reporting period;
- be completed using the accrual, modified accrual, or cash basis method of accounting for governmental entities;
- reconcile to the district's trial balance and general ledger accounts;
- report dollar amounts properly rounded to the nearest dollar and report statistical information to two decimal places;
- calculate all percentages used in calculations to at least two decimal places;
- have complete edit explanations with sufficient detail to explain all variances;
- be submitted in the SHARS web-based cost report system; and
- have signed, notarized, original certification pages uploaded and submitted in STAIRS on or before the posted due date.

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SHARS Provider Data (Step 1)

Consists of the following:

- District Identification
- SHARS Provider Identification
- Financial Contact
- Report Preparer Identification
- Location of Accounting Records That Support This Report
- Cooperative Information

General and Statistical Information (Step 2)

Cost are allocated using statistics approved by CMS to facilitate the identification of costs associated with Medicaid.

There are four key allocation methods used in the cost report: (1) an allocation method to identify the cost of medical services irrespective of payer and administrative cost; (2) a method for allocating direct medical services costs to the Texas Medicaid program; (3) a method for allocating transportation costs that cannot be direct costed to specialized transportation services; and (4) a method for allocating specialized transportation based on the one-way trip ratio.

General and Statistical Information (Step 2) (continued)

COST ALLOCATION METHODS:

- Direct Services Time Study Percentage – Reports the amount of time related to all medical services and Medicaid administrative claiming as derived from data obtained from the RMTS (statewide time study).
- Direct Medical Services IEP Ratio – (Total number of Medicaid students with IEPs requiring medical services)/(Total number of students with IEPs requiring medical services)

  Medical IEPs refers to students with IEPs that document the need for a direct medical service. Direct Medical Services IEP Ratio = (The total number of Medicaid students with IEPs requiring medical services) / (The total number of students with IEPs requiring medical services).
- The third allocation method used in the cost report is for transportation costs that cannot be direct costed to specialized transportation services, e.g., fuel, insurance, and/or bus mechanic costs. It is referred to as the Specially-Adapted Vehicles Ratio.

  If costs cannot be direct costed to specialized transportation services, it is acceptable to allocate the costs to specialized transportation service based on calculating (the number of specialized transportation vehicles) / (the total number of transportation vehicles).
- The fourth allocation method, the One-Way Trip Ratio, is the ratio of one-way specialized transportation trips provided on a day when medical services pursuant to an IEP were provided divided by the total number of one-way specialized transportation trips.

  One-way Trip Ratio = (total one-way trips for Medicaid students with IEPs requiring specialized transportation services) / (total one-way trips for all students with IEPs requiring specialized transportation services).

General and Statistical Information (Step 2)

IEP Ratio = (Total number of Medicaid students with IEPs requiring medical services)/(Total number of students with IEPs requiring medical services)

Total Student Population

Special Education Students

Students with IEPs that prescribe SHARS

Medicaid Eligible Students with IEPs that prescribe SHARS

Direct Medical Services Individualized Education Program (IEP) Ratio	
00.00.10 Total # of Medicaid students with IEPs requiring direct medical services	12
00.00.11 Total # of students with IEPs requiring direct medical services	12
00.00.12 IEP ratio (item 00.00.10 divided by item 00.00.11)	100%

General and Statistical Information (Step 2)

- Specialized Transportation Services IEP Ratio – (Total number of Medicaid students requiring specialized transportation services)/(Total number of students requiring specialized transportation services)

- Specially-Adapted Vehicles Ratio – Used to allocate transportation costs that cannot be direct costed to specialized transportation services, e.g., fuel, insurance, and/or mechanic costs. (Total number of specially adapted vehicles)/(Total number of vehicles)

- One-Way Trip Ratio – (Total one-way trips for Medicaid students with IEPs requiring specialized transportation services)/(Total one-way trips for all students with IEPs requiring specialized transportation services)

Specialized Transportation Services One-Way Trip Ratio	
00.00.13 Total number of one-way trips for Medicaid students with IEPs requiring specialized transportation services	71,026
00.00.14 Total number of one-way trips for students with IEPs requiring specialized transportation	150,409
00.00.15 One-Way Trip Ratio (item 00.00.13 divided by item 00.00.14)	47.22%

General and Statistical Information (Step 2)

Reimbursement for covered transportation services is calculated on a student one-way trip* basis, as long as the student receives at least one direct medical service on the same day.

*Important: If the student receives a billable SHARS service that is documented in his/her IEP (including personal care services on the bus) and is transported on a specially adapted vehicle, the following one-way trips may be claimed:

1. From the student's residence to school
2. From the school to the student's residence
3. From the student's residence to a provider's office that is contracted with the district
4. From a provider's office that is contracted with the district to the student's residence
5. From the school to a provider's office that is contracted with the district
6. From a provider's office that is contracted with the district to the student's school
7. From the school to another campus to receive a billable SHARS service
8. From the campus where the student received a billable SHARS service back to the student's school
9. For more information on SHARS Transportation see: *Texas Medicaid Provider Procedure Manual – Children's Services Handbook, Vol. 2, Section 3.3.10 Transportation Services in a School Setting*

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General and Statistical Information (Step 2)

- All 5 allocation ratios/methods are listed in the General & Statistical Information section of the SHARS Cost Report.
- Each district's General Provider Information, Unrestricted Indirect Cost Rate, and Direct Medical Services Percentage Derived From Approved Time Study (Direct Services Time Study Percentage) are provided by HHSC.
- The Direct Medical Services IEP Ratio, Specialized Transportation Services IEP Ratio, Specially-Adapted Vehicles Ratio, and One-Way Trip Ratio are calculated within the cost report using data entered by the preparer.

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IEP Ratio Supporting Documentation

- **Provide a Medicaid eligibility list which includes:**
  - A Medicaid column
    - For students that are Medicaid, please provide their Medicaid number. For those that aren't, please leave blank.
  - Provide the formula/method used to calculate the IEP ratio

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Transportation Ratio Supporting Documentation

- **Provide actual trips logs with the following elements:**
  - Log filled daily by the bus driver, not the monitor
  - Signature on each log by the bus driver, dated in the appropriate month/year
  - Any changes in the log need to be initialed by the bus driver
  - Route name/number
  - District name
  - Logs need to be from the cost report period anything outside of these dates cannot be included in ratio
  - Provide documentation or confirm that another direct medical service was provided the same day as each trip (needs to be available in the event of an audit)
  - Provide a Medicaid eligibility list

Note: Bus monitors ***CANNOT*** sign for Bus Drivers

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Direct Medical Services Data (Step 3)

- The purpose of the SHARS Cost Report is to:
  - Capture Medicaid-allowable costs for the CMS-approved personnel delivering direct medical services; and
  - Capture Medicaid-allowable costs associated with specialized transportation services, in accordance with the CMS-approved Texas Medicaid State Plan.
- Direct Medical Services Data can be entered in summary (Step 3a).

Direct Medical Services Data (Step 3)

Direct Medical Services Employee Information:

- In step 3, the data for Provider Category, External ID, Name, Employment Type, Title, and Quarters Reported on Participant List is pre-populated based on information reported on the district's participant lists throughout the cost report period.
- All Employee Information, excluding the quarters reported on the district's participant list, can be edited in Step 3.
- Employee Information is summarized and reduced to Provider Category, Number of Employees (headcount), and Number of Contactors (headcount) in Step 3.
- SSA/Co-Op employees are to be recorded in the cost report as employees by the SSA/Co-Op fiscal agent. If these individuals provide services at the other member districts of the SSA/Co-Op, the member districts should record their portion of the costs as contractor costs.
- Any worker that only works for an ISD should be reported as an employee on the ISD's cost report.

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Direct Medical Services Data (Step 3)

Direct Medical Services Employee Information:

If an employee or contracted staff member only provides supervisory services and does not deliver any direct medical services to clients, that individual's paid hours & costs should NOT be reported on the cost report.

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Direct Medical Services Data (Step 3)

Direct Medical Services Payroll, Benefits, and Taxes:

- **Hours** - Total hours paid to an employee/contractor for direct medical services provided to the district's Medicaid and/or non-Medicaid clients during the quarters the employee/contractor was included on the district's participant list. Hours includes overtime, travel time, documentation time, training time, staff meeting time, paid vacation time, and paid sick leave time relating to the Gross Salary/Contractor Payments reported for the employee/contractor. Employee hours and Contractor Hours are reported separately in Step 3b.
- **Gross Salary/Contractor Payments** – Salary/payments paid to an employee or contractor (before taxes or any deductions) for the hours he/she provided direct medical services to the district's Medicaid and/or non-Medicaid clients during the quarters the employee/contractor was included on the district's participant list. Gross Salary/Contractor Payments includes overtime pay, cash bonuses, and any cash incentives paid from which payroll taxes are (or should be) deducted. Gross Salaries and Contractor Payments are reported separately in Step 3b.
- ***Note: Districts should be prepared to justify higher than average salaries for employees and contractors***

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Direct Medical Services Data (Step 3)

Direct Medical Services Payroll, Benefits, and Taxes:

- Report 100% of the salary payments for ALL eligible participants on the participant list (PL) for the quarters the positions were included on the district's PL.
- Costs reported are "position-specific" not "person-specific".
  - Example: Position #85 had the following employee changes from January – March:
    - Employee A works Jan 1 thru Jan 19, earns $800
    - Substitute A works Jan 20 thru Feb 28, earns $1,200
    - Employee B works March 1 thru March 31, earns $1,500
    - The total SHARS Reportable Expenditure for Position #85 is $800 + $1,200 + $1,500 = $3,500

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Direct Medical Services Data (Step 3)

Direct Medical Services Payroll, Benefits, and Taxes:

- **Employer-Paid Retirement** – Direct costed, employer-paid retirement contributions made by the district for a direct medical services employee during the quarters the employee was listed on the district's participant list.
- **Employer-Paid FICA** – Direct costed, employer-paid Federal Insurance Contributions Act (FICA) contributions made by the district for a direct medical services employee during the quarters the employee was listed on the district's participant list.
- **Employer-Paid Medicare** – Direct costed, employer-paid Medicare contributions paid for a direct medical services employee during the quarters the employee was listed on the district's participant list.

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Direct Medical Services Data (Step 3)

Direct Medical Services Payroll, Benefits, and Taxes:

- **State Unemployment (Payroll Taxes or Reimbursing Employer Costs)** – The direct costed, employer-paid Texas Unemployment Compensation Act (TUCA) contributions paid for a direct medical services employee during the quarters the employee was listed on the district's participant list. Reimbursing employers that pay into an unemployment account in lieu of taxes should report the actual amount of unemployment compensation paid for any direct medical services staff members.
- **Federal Unemployment** – The direct costed, employer-paid Federal Unemployment Taxes Act (FUTA) contributions paid for a direct medical services employee during the quarters the employee was listed on the district's participant list.
- **Worker's Compensation Costs (including Self-Insurance Costs)** - Costs for direct medical services staff must be reported with amounts accrued for premiums, modifiers, and surcharges, and net of any refunds and discounts actually received or settlements paid during the quarters the employee was listed on the district's participant list. Costs related to self-insurance are allowable on a claims-paid basis and are to be reported on a cash basis. Contributions to self-insurance funds that do not represent payments based on current liabilities are unallowable costs.

Direct Medical Services Data (Step 3)

Direct Medical Services Payroll, Benefits, and Taxes:

- **Other Benefit** – Any direct costed, employer-paid benefits paid on behalf of a direct medical services employee during the quarters the employee was included on the district's participant list other than dental, disability, health, or life insurance premiums or employer-paid child day care.
- **Child Day Care** – Employer-paid child day care costs for the children of a direct medical services employee paid as employee benefits during the quarters the employee was included on the district's participant list.
- **Dental Insurance** – The direct costed, employer-paid dental insurance premiums for a direct medical services employee during the quarters the employee was included on the district's participant list.
- **Disability Insurance** – The direct costed, employer-paid disability insurance premiums for a direct medical services employee during the quarters the employee was included on the district's participant list.
- **Health Insurance** – The direct costed, employer-paid health insurance premiums for a direct medical services employee during the quarters the employee was included on the district's participant list.
- **Life Insurance** – The direct costed, employer-paid life insurance premiums for a direct medical services employee during the quarters the employee was included on the district's participant list.

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Direct Medical Services Data (Step 3)

Provider Category	Number of Employees (headcount)	Number of Contractors (headcount)	Employee Hours	Contractor Hours	Gross Salaries	Contractor Payments	Employer-Paid Retirement	Employer-Paid FICA	Employer-Paid Medicare	Federal Funding Amount	State Unemployment (Payroll Taxes or Reimbursing Employer Costs)	Federal Unemployment	Worker's Compensation Costs (including Self-Insurance Costs)	Child Day Care	Dental Insurance	Disability Insurance	Health Insurance	Life Insurance	Other Benefit
Audiologist	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Audiology Assistant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Counselor	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Delegated Nursing	1	0	1,011.17	0	$18,201	0	$410	0	$264	0	0	0	0	0	0	0	$8	0	0
LVN & LPN	4	0	6,592.15	0	$118,659	0	$2,492	$0	$1,677	0	$0	$0	$0	$0	$0	$0	$2,957	$0	$0
RN & APN	1	0	1,539.17	0	$46,175	0	$1,174	$0	$626	0	$0	$0	$0	$0	$0	$0	$2,708	$0	$0
Occupational Therapist	0	1	0	1,097.37	0	$41,700	0	0	0	0	0	0	0	0	0	0	0	0	0
Occupational Therapy Assistant	0	2	0	3,325.56	0	$76,488	0	0	0	0	0	0	0	0	0	0	0	0	0
Personal Care Services	31	1	53,973.92	1,941.35	$1,142,661	$44,651	$31,374	$0	$11,800	$275,098	$0	$0	$0	$0	$0	$0	$69,262	$0	$0
Physical Therapist	0	1	0	729.63	0	$23,348	0	0	0	0	0	0	0	0	0	0	0	0	0
Physical Therapy Assistant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Physician	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Psychologist	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Speech Pathologist	2	0	2,878.47	0	$109,382	0	$3,144	$0	$1,545	0	$0	$0	$0	$0	$0	$0	$16	$0	$0
Speech Pathologist Assistant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

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Direct Medical Services Data (Step 3)

Federal Funding Reduction:

Federal Funding Amount (including ARRA funds) – The federal grants, matching funds, and/or ARRA/Stimulus funds received by the district for a direct medical services employee/contractor during the quarters the employee/contractor was included on the district's participant list. The Federal Funding Reduction column is used to subtract the federal funds applied to the costs that were included in the Payroll Taxes & Benefits columns to arrive at the net cost for the employee/contractor.

NOTE: MAC funds are considered "reimbursement" funds and are not required to be backed out.

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Direct Medical Services Data (Step 3)

Steps 3b and 3c of the cost report are used to document direct costed supplies, materials, and certain allowable expenses related to all services.

- Do not report supplies or materials that support administrative services.
- If costs were not reported for a cost category in Step 3a of a district's cost report, the district will not be allowed to report costs for that cost category in Steps 3b or 3c.

Cost Category	Direct Medical Travel	Required Continuing Education	Appendix A Other Direct Medical (less than $5,000)	Other Reductions
	Enter Detail	Enter Detail	Enter Detail	Enter Detail
Nursing Services	0	0	$773	0
Occupational Therapy (OT)	0	0	$7,992	0
Personal Care Services	0	0	$3,239	0
Physical Therapy (PT)	0	0	$836	0
Speech and Language Services (SLP)	0	0	$4,458	0

Direct Medical Services Data (Step 3)

3b. Direct Medical Services Other Costs Summary Data (Includes Appendix A less than $5,000)

- **Required Continuing Education** - Allowable expenditures include training and continuing education seminars, travel, and other staff costs to maintain professional licensure and/or certification. Education and/or training costs are not allowable for staff pursuing licensure or certification as a new profession.
- *Note: There is **NO** certification/licensure required to be a PCS provider. As a result, no continuing education costs can be claimed under PCS.*

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Direct Medical Services Data (Step 3)

3b. Direct Medical Services Other Costs Summary Data (Includes Appendix A less than $5,000)

- **Direct Medical Travel** - Travel costs incurred by district employees to provide direct medical services to a recipient. Allowable staff travel expenditures include mileage reimbursements, fuel allowances/reimbursements, cab or bus fare, hotel, and other travel reimbursements paid to staff.
- *Note: There is **NO** certification/licensure needed to be a PCS provider. As a result, no travel costs incurred from continuing education costs can be claimed under PCS.*

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Direct Medical Services Data (Step 3)

3b. Direct Medical Services Other Costs Summary Data (Includes Appendix A less than $5,000)

- **Appendix A Other Direct Medical (less than $5,000)** - Appendix A is an all inclusive list of Medicaid-allowable costs for direct medical services. The list provided in Appendix A includes CMS approved materials and supplies. Any request for additional items not included will require CMS approval. The total cost of Appendix A items reported is allowable if the materials and supplies are **only dedicated to the provision of direct medical services.**
- *Note: Supplies and materials associated with academics are **NOT** an allowable costs under Appendix A.*

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Direct Medical Services Data (Step 3)

3b. Direct Medical Services Other Costs Summary Data (Includes Appendix A less than $5,000)

- **Other Reductions** - Other funding by which costs are reduced would include recovery of costs. For example, if an insurance claim were filed and the insurance company made a payment to the provider, the payment would be considered a recovery of costs and should be reported as a reduction to costs.
- *Note: costs that belong in other categories such as Direct Medical Travel or Required Continuous Education should **NOT** be included in this category.*

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Direct Medical Services Data (Step 3)

3b. Direct Medical Services Other Costs Summary Data (Includes Appendix A less than $5,000)

Each cost entered in Step 3b will require four key components:

1. Cost category (drop-down menu varies by cost item)
2. Amount
3. Federal Funding Amount
4. Type (drop-down menu varies by cost item)

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Direct Medical Services Data (Step 3)

3c. Appendix A – Depreciation of Direct Medical Services Materials & Supplies ($5,000 or over)

- Appendix A items costing $5,000 and over should be documented for depreciation in Step 3c.
  - Depreciation is the periodic reduction of the value of an asset over its useful life or the recovery of the asset's cost over the useful life of the asset.
- Allowable depreciation expense for direct medical services includes only pure straight-line depreciation. Any single item purchased during the cost-reporting period costing less than $5,000 must be expensed and reported accordingly in Step 3b.
- Refer to the Cost Reporting Instructions manual for more information on depreciation of assets.

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Updated Appendix A

- Please note that we now have an updated Appendix A list which will be available on our website.
  - Review the list carefully and ensure that you have relevant documentation to support the items claimed.
- Please also note that the items claimed must be medically necessary.

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Appendix A Supporting Documentation

- Adequate documentation for seminars/conferences includes:
- A program brochure describing the seminar or a conference program with a description of the workshop attended.
- The documentation must clearly demonstrates that the seminar/ conference/ workshop provided training required to maintaining professional licensure/ certification.

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Appendix A Supporting Documentation cont'd

- At a minimum, documentation for purchased Appendix A items should include accounting ledgers, invoices, purchase orders, vouchers, canceled checks, mileage logs, flight logs, asset records, inventory records, verification of credentials, and/or cost allocation spreadsheets.

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Transportation Data (Step 4)

Transportation services in a school setting may be reimbursed when they are provided on a specially adapted vehicle and if the following criteria are met:

- Service provided to or from a Medicaid-covered service on the day for which the claim is made
- A child requires transportation in a specially-adapted vehicle to serve the needs of the disabled
- A child resides in an area that does not have school bus transportation, such as those in close proximity to a school
- The Medicaid services covered by SHARS are included in the student's IEP
- The special transportation service is included in the student's IEP

Transportation Data (Step 4)

A specially adapted vehicle is one that has been physically modified (e.g. addition of wheelchair lift, addition of harnesses/protective restraint devices, addition of child protective seating or addition of air conditioning).

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Transportation Data (Step 4)

Transportation Services (Only Specialized Trans.)

- Reflects transportation employees/contractors whose transportation duties are to service and/or drive a specially adapted vehicle.
- Reduced by the One-Way Trip Ratio.
  - One-Way Trip Ratio = (Total one-way trips for Medicaid students with IEPs requiring specialized transportation services)/(Total one-way trips for all students with IEPs requiring specialized transportation services)

Transportation Services (Not Only Specialized Trans.)

- Reflects transportation employees/contractors whose servicing and/or driving duties float between specially adapted vehicles and regular transportation vehicles.
- Reduced by the Specially-Adapted Vehicles Ratio & the One-Way Trip Ratio.
  - Specially-Adapted Vehicles Ratio = (Total number of specially adapted vehicles)/(Total number of vehicles)
  - One-Way Trip Ratio = (Total one-way trips for Medicaid students with IEPs requiring specialized transportation services)/(Total one-way trips for all students with IEPs requiring specialized transportation services)

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Transportation Data (Step 4)

Transportation Employee Information:

- Employee information consists of Provider Category, External ID, Name, and Employment Type.
  - Provider Category – Employees and contractors should be designated as "Only Specialized Trans" or "Not Only Specialized Trans." If a transportation employee or contractor's costs cannot be direct costed to only specialized transportation or the individual's duties included driving and/or servicing both specially adapted vehicles and regular transportation vehicles the employee should be designated as "Not Only Specialized Trans." *See Cost Report Manual for more information*.
  - Employment Type – Full Time, Part Time or Contract
- Most employee information data can be added and/or edited from Step 4a or 4b.
- Employee information reported in Step 4a is summarized and reduced to Provider Category, Number of Employees (headcount), and Number of Contractors (headcount) in Step 4b.

Transportation Payroll, Taxes and Benefits:

- **Hours** – Total hours paid to the transportation staff member (district employee or contractor) during the cost report period. Transportation staff includes bus drivers, mechanics, and mechanic assistants. Hours include overtime, travel time, documentation time, training time, staff meeting time, paid vacation time, and paid sick leave time relating to the Gross Salary/Contractor Payments reported for the staff member. **Employee Hours** and **Contractor Hours** are reported separately in Step 4b.

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Transportation Data (Step 4)

Transportation Payroll, Taxes and Benefits:

- **Gross Salary/Contractor Payments** – Salary/payments paid to an employee or contractor (before taxes or any deductions) for the hours he/she provided transportation services as a bus driver, mechanic, or mechanic assistant. Gross Salary/Contractor Payments includes overtime pay, cash bonuses, and any cash incentives paid from which payroll taxes are (or should be) deducted. **Gross Salaries** and **Contractor Payments** are reported separately in Step 4b.
- **Employer-Paid Retirement** – Direct costed, employer-paid retirement contributions made by the district for a transportation employee during the federal fiscal year in which the individual served as a bus driver, mechanic, or mechanic assistant for the district.
- **Employer-Paid FICA** – Direct costed, employer-paid FICA contributions made by the district for a transportation employee during the federal fiscal year in which the individual served as a bus driver, mechanic, or mechanic assistant for the district.
- **Employer-Paid Medicare** – Direct costed, employer-paid Medicare contributions paid for a transportation employee during the federal fiscal year in which the individual served as a bus driver, mechanic, or mechanic assistant for the district.

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Transportation Data (Step 4)

- **State Unemployment (Payroll Taxes or Reimbursing Employer Costs)** – The direct costed, employer-paid Texas Unemployment Compensation Act (TUCA) contributions paid for a transportation employee during the federal fiscal year in which the individual served as a bus driver, mechanic, or mechanic assistant for the district. Reimbursing employers that pay into an unemployment account in lieu of taxes should report the actual amount of unemployment compensation paid for the transportation staff member.

- **Federal Unemployment** – The direct costed, employer-paid Federal Unemployment Taxes Act (FUTA) contributions paid for a transportation employee during the federal fiscal year in which the individual served as a bus driver, mechanic, or mechanic assistant for the district.

- **Worker's Compensation Costs (including Self-Insurance Costs)** - Costs for transportation staff must be reported with amounts accrued for premiums, modifiers, and surcharges, and net of any refunds and discounts actually received or settlements paid during the federal fiscal year the employee served as a bus driver, mechanic, or mechanic assistant for the district. Costs related to self-insurance are allowable on a claims-paid basis and are to be reported on a cash basis. Contributions to self-insurance funds that do not represent payments based on current liabilities are unallowable costs.

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Transportation Data (Step 4)

Transportation Payroll, Taxes and Benefits:

- **Other Benefit** – Any direct costed, employer-paid benefits paid on behalf of a transportation services employee other than dental, disability, health, or life insurance premiums or employer-paid child day care during the federal fiscal year the employee served as a bus driver, mechanic, or mechanic assistant for the district.
- **Child Day Care** – Employer-paid child day care costs for the children of a transportation services employee paid as employee benefits during the federal fiscal year the employee served as a bus driver, mechanic, or mechanic assistant for the district.
- **Dental Insurance** – The direct costed, employer-paid dental insurance premiums for a transportation services employee during the federal fiscal year the employee served as a bus driver, mechanic, or mechanic assistant for the district.
- **Disability Insurance** – The direct costed, employer-paid disability insurance premiums for a transportation services employee during the federal fiscal year the employee served as a bus driver, mechanic, or mechanic assistant for the district.
- **Health Insurance** – The direct costed, employer-paid health insurance premiums for a transportation services employee during the federal fiscal year the employee served as a bus driver, mechanic, or mechanic assistant for the district.
- **Life Insurance** – The direct costed, employer-paid life insurance premiums for a transportation services employee during the federal fiscal year the employee served as a bus driver, mechanic, or mechanic assistant for the district.

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Transportation Data (Step 4)

Federal Funding Reduction:

Federal Funding Amount (including ARRA funds) – The federal grants, matching funds, and/or ARRA/Stimulus funds received by the district for a transportation employee/contractor during the federal fiscal year in which the individual served as a bus driver, mechanic, or mechanic assistant for the district. *The Federal Funding Reduction column is used to subtract the federal funds applied to the costs that were included in the Payroll, Taxes & Benefits columns to arrive at the net cost for the employee.*

NOTE: MAC funds are considered "reimbursement" funds and are not required to be backed out.

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Transportation Data (Step 4)

4c. Transportation Other Costs Summary Data

In addition to payroll expenses, SHARS allows school districts to report other costs incurred by the district's staff/contractors to provide specialized transportation services. The other costs that can be reported in Step 4c should be reported as either Transportation Services (only Specialized Trans) or Transportation Services (not only Specialized Trans). The costs allowable in this section include:

- **Required Continuing Education** – Allowable expenditures include training and continuing education seminars, travel, and other staff costs to maintain professional licensure and/or certification. *Education and/or training costs are not allowable for staff pursuing licensure or certification as a new profession*.
- **Private Payments to Parents/Guardians** – Payments made to parents for specialized transportation one-way trips. *See Cost Report Manual for more information on Private Payments to Parents/Guardians*.
- **Other Reductions** – Includes federal funding for any of the costs reported for specialized transportation services. Specialized transportation services costs are not reduced by MAC funding. An example of federal funding to be reported as a reduction to costs is funding through the Individuals with Disabilities Education Act (IDEA).

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Transportation Data (Step 4)

4d. Worksheet C – Other Transportation Costs

Like Step 4c, Step 4d allows cost report preparers to enter other transportation costs. Section 4d allowable costs are those expenses that resulted from the district's use of transportation equipment/services. Like Step 4c costs, the allowable costs a district can claim in Section 4d should be submitted under the appropriate Cost Category (Transportation Services – only Specialized Trans or Transportation Services – not only Specialized Trans) to ensure that data is properly calculated by the annual cost report system. The Step 4d allowable Cost Types include:

- **Contract-Transportation Equipment** - Report costs of contracted specialized transportation equipment.
- **Contract-Transportation Services** - Report costs of contracted specialized transportation services.
- **Fuel and Oil** - Report gasoline, diesel, other fuel and oil costs for specialized transportation vehicles.
- **Insurance** - Report the cost for insurance premiums for specialized transportation vehicles. Costs should be reported with amounts accrued for premiums, modifiers, and surcharges and net of any refunds and discounts actually received or settlements paid during the same cost reporting period.
- **Lease/Rental** - Report the lease/rental costs of specialized transportation equipment as indicated. If a vehicle lease includes both specialized transportation equipment and non-specialized transportation equipment, allocate the costs based on the number of leased specialized transportation equipment items divided by the total number of leased transportation equipment items and report the amount as "Transportation Services (only Specialized Trans)" or report the total cost as "Transportation Services (not only Specialized Trans)."

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Transportation Data (Step 4)

4d. Worksheet C – Other Transportation Costs

- **Maintenance and Repairs** – Report repairs and maintenance, including non-depreciable tune-ups, oil changes, cleaning, licenses, inspections, and replacement parts due to normal wear and tear for specialized transportation vehicles. Report maintenance supplies related to specialized transportation vehicles. Major vehicles repairs costing $5,000 or more must be depreciated and reported as "Depreciation-Transportation Equipment."
- **Major Purchases Under $5,000** – Report non-depreciable equipment purchases required to maintain and repair specialized transportation equipment as purchases under $5,000.
- **Other** – Direct costed supplies and materials related to specialized transportation equipment and/or services other than those specifically identified in this section.

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Transportation Data (Step 4)

Contract Transportation Services/Equipment

Many districts use contractors to provide transportation services for their students. This cost can be claimed in the SHARS cost report in **Step 4d**. The method of determining the allowable cost to the report can vary based on the terms of each individual district's negotiated contract. To determine if the cost is allowable and what percentage of the cost is allowable, the district must evaluate the contract to determine what costs contribute to Specialized Transportation. If the contract has a direct cost impact, determine the allocation that will justify the appropriate amount specific to Specialized Transportation. The district must be able to provide supporting documentation to justify the allocation. Consider the following when evaluating and reporting costs:

- If a district owns the vehicles the contractor used to provide transportation services, the district should identify the owned vehicles under the Specially-Adapted Vehicle Ratio in Step 2 (Lines 00.00.16 & 00.00.17) of the cost report. The cost report preparer can then either allocate the total contract transportation services/equipment cost into "only specialized trans" and "not only specialized trans," or simply report the total expense as "not only specialized trans."

- If a district does not own the vehicles used to provide transportation services, it should report its contractor's Specially-Adapted Vehicle Ratio in Section 2 (Lines 00.00.16 & 00.00.17) of the cost report. The ratio should only include the contractor's vehicles used to provide services to the district. The cost report preparer can then either allocate the total contract transportation services/equipment cost into "only specialized trans" and "not only specialized trans," or simply report the total expense as "not only specialized trans".

If neither of the scenarios above describes the district's contract of transportation services/equipment arrangement, please contact the SHARS rate analyst for assistance.

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Transportation Data (Step 4)

4d. Worksheet C – Other Transportation Costs

All Step 4d costs should be recorded under the appropriate cost category and should include:

- Gross Costs
- Federal Funding Amount
- Other Reductions – other funding by which costs are reduced would include recovery of costs. For example, if an insurance claim were filed and the insurance company made a payment to the provider, the payment would be considered the recovery of costs and should be reported under "Other Reductions."

Federal Funding Amounts and Other Reductions are auto-summed within Section 4d to arrive at the Total Reductions amount. All Step 4d cost components are auto-summed and used in the annual cost report's total SHARS calculations in Step 5.

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Transportation Data (Step 4)

4e. Depreciation – Transportation Services (Specially-Adapted Vehicles Only)

Depreciation is the periodic reduction of the value of an asset over its useful life or the recovery of the asset's cost over the useful life of the asset. Allowable depreciation expense for specialized transportation services includes only pure straight-line depreciation and is limited to specially adapted vehicles. No accelerated or additional first-year depreciation is allowed. In Step 4e:

- Each depreciable item must be reported individually. Items should not be combined under generic descriptions such as "various" or "equipment."
- Detail data is required for each item reported. The data is used to auto-calculate the item's depreciation.
- Years of Useful Life is pre-programmed for each type of depreciable asset that can be reported.
- The annual cost report will auto-update a depreciable item's "Prior Period Accumulated Depreciation" each year until the item has reached the end of its useful life.
- Current depreciation for depreciable items is calculated within the annual cost report in this section and is then transferred to the cost report's Transportation Services table as "Other Costs" for cost category "Transportation Services (only Specialized Trans)." The amount is then used to calculate the district's Medicaid allowable (transportation) costs.

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Transportation Data (Step 4)

4e. Depreciation – Transportation Services (Specially-Adapted Vehicles Only)

Any single (transportation) item purchased during the cost-reporting period costing less than $5,000 must be expensed and reported accordingly in Step 4d.

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Preparer Verification Summary (Step 5)

In Step 5, all the cost entries submitted by a preparer are summarized and totaled by cost category and then presented to the preparer for review.

A SHARS Financial Contact must review the district's data to verify that all costs listed are accurate.

Once the data has been approved, the contact must then submit the cost report to HHSC.

Preparer Verification Summary (Step 5)

Direct Medical Services

Cost Category	Employee Salary	Other Costs	Federal Funds and Other Reductions	Net Direct Costs (less reductions & Federal Funds)	Indirect Costs	Net Direct Costs plus Indirect Costs	Application of Direct Medical Percetnage	Application of IEP Ratio	Medicaid Allowable Costs
Calculations	(A)	(B)	(C)	(D) A + B - C	(E) D * UICR %	(F) D + E	(G) F * Direct Medical %	(H) G * IEP Ratio	
Audiology & Hearing	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Counseling Services	$1,365.00	$0.00	$0.00	$1,365.00	$265.30 History	$1,630.30 History	$690.60 History	$193.37	$193.00
Nursing Services	$29,025.00 History	$4,077.00 History	$0.00	$33,102.00 History	$6,433.70 History	$39,535.70 History	$16,747.32 History	$4,689.25	$4,689.00 History
Occupational Therapy (OT)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Personal Care Services	$42,867.00 History	$4,625.00 History	$0.00	$47,492.00 History	$9,230.55 History	$56,722.55 History	$24,027.67 History	$6,727.75	$6,728.00 History
Physical Therapy (PT)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Physician Services	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Psychological Services	$5,326.00	$0.00	$0.00	$5,326.00	$1,035.16 History	$6,361.16 History	$2,694.59 History	$754.48	$754.00
Speech and Language Services (SLP)	$18,510.00	$0.00	$0.00	$18,510.00	$3,597.60 History	$22,107.60 History	$9,364.78 History	$2,622.14	$2,622.00
Total	$97,093.00 History	$8,702.00 History	$0.00	$105,795.00 History	$20,562.32 History	$126,357.32 History	$53,524.96 History	$14,986.99	$14,987.00 History

Preparer Verification Summary (Step 5)

Transportation Services

Cost Category	Employee Salary	Other Costs	Federal Funds and Other Reductions	Net Direct Costs (less reductions & Federal Funds)	Indirect Costs	Net Direct Costs plus Indirect Costs	Application of Specifically Adapted Vehicles Percentage	Application of One-Way Trip Ratio	Medicaid Allowable Costs
Calculations	(A)	(B)	(C)	(D) A + B - C	(E) D * UICR %	(F) D + E	(G) F * Specifically Adapted Vehicles Ratio	(H) G * One-Way Trip Ratio	
Transportation Services (only Specialized Trans)	$17,616.00	$2,443.00	$0.00	$20,059.00	$3,618.44 History	$23,677.44 History	$23,677.44 History	$23,677.44 History	$23,677.00
Transportation Services (not only Specialized Trans)	$3,684.00	$30,883.07 History	$0.00	$34,567.07 History	$6,235.55 History	$40,802.62 History	$14,125.87 History	$14,125.87 History	$14,126.00 History
Total	$21,300.00	$33,326.07 History	$0.00	$54,626.07 History	$9,854.00 History	$64,480.07 History	$37,803.31 History	$37,803.31 History	$37,803.00 History

Total SHARS

Cost Category	Employee Salary	Other Costs	Federal Funds and Other Reductions	Net Direct Costs (less reductions & Federal Funds)	Indirect Costs	Net Direct Costs plus Indirect Costs	Application of Direct Medical Percentage/Specially Adapted Vehicles Percentage	Application of IEP Ratio/One-Way Trip Ratio	Medicaid Allowable Costs
Grand Total	$574,608.00 History	$64,467.07 History	$44,091.00 History	$594,984.07 History	$107,329.18 History	$702,313.25 History	$307,989.45 History	$253,168.68 History	$253,168.68 History

Preparer Certification (Step 6)

- Once the cost report has been submitted, districts must sign and upload a Preparer Certification Form.
  - ***If the forms are not completed properly, the cost report will not be processed until the provider makes the necessary corrections.***

Upload Preparer Certification (Step 7)

- Prior to the 2011 cost report year, providers were required to mail their certification forms to HHSC.
- STAIRS now requires users to upload these forms directly to the system.
- Maintain originals with the district's records.

Entity Certification (Step 8)

- Once the cost report has been submitted, districts must sign and upload a Preparer Citification Form.
  - ***If the forms are not completed properly, the cost report will not be processed until the provider makes the necessary corrections.***

Upload Entity Certification (Step 9)

- Prior to the 2011 cost report year, providers were required to mail their certification forms to HHSC.
- STAIRS now requires users to upload these forms directly to the system
- Maintain originals with the district's records.

Provider Adjustment Report (Step 10)

- Following submission of the Cost Report, the Cost Reports are audited by HHSC Cost Report Review Unit (CRRU) and then by HHSC Provider Finance
- Step 10 includes all adjustments made by CRRU and Provider Finance
- The cost reconciliation process must be completed within 24 months of the end of the reporting period covered by the annual SHARS cost report.
- If a provider has not complied with all cost report requirements HHSC will recoup all federal funds issued as interim payments for services delivered during the reporting period.
- The total Medicaid-allowable costs are compared to the provider's interim payments for SHARS delivered during the reporting period, which results in a cost reconciliation.

Provider Adjustment Report (Step 10)

- HHSC retains one percent of the federal share of the total certified Medicaid allowable cost as an administrative fee to be used for Health and Human Services administrative activities.
- If 99 percent of the provider's federal portion of the total certified Medicaid allowable costs exceeds the interim Medicaid payments, HHSC will pay the difference to the provider in accordance with the final actual certification agreement.
- If a provider's interim payments exceed 99 percent of the provider's federal portion of the total certified Medicaid allowable costs, the provider must repay the over payments or HHSC will offset all of the provider's future claims payments until the amount is recovered.

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Agree/Disagree (Step 11)

- HHSC issues a notice of settlement that denotes the amount due to or from the provider. Notices are issued by December 2nd each year.
- The district must log into STAIRS within 30 days of the date of the notice to "Agree" or "Disagree" with the proposed settlement.
- HHSC will process the payout or recoupment listed for districts that Agree.
- If no response is received from a district within the allotted time frame, *STAIRS will agree with the settlement by default*.
  - Once a district agrees with its settlement, if it is owed money, it will receive the settlement payment within 60 days after HHSC submits the action request to TMHP.
- An ISD Superintendent, CFO, Business Officer, or other ISD Official with legal authority who disagrees with the adjustments made during the cost reconciliation process has the right to request an informal review of the adjustments.
  - If a district does not submit an informal review request, no action will be taken as a result of its "Disagree" response.
  - A "Disagree" response reflects a disagreement with the contained data. It is not an opportunity to submit additional claims material.

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Informal Review (Step 12)

- Informal review requests must be sent by certified mail and received by HHSC by the due date listed on the settlement notice.
  - **HHSC will no longer accept informal review requests via email.** All requests must be submitted to HHSC by the due date listed on the settlement notice via hand delivery, US mail, or special delivery, as specified in Rule §355.110.
  - Extensions for submitting an informal review request can be submitted to HHSC Provider Finance Department, refer to Rule §355.110 for details regarding extension requests.
- The request must include a concise statement of the specific actions or determinations being disputed, the ISD's recommended resolution, & any supporting documentation deemed relevant.
- Failure to follow these instructions will result in the denial of the request. If a district's request is denied, HHSC will proceed with the settlement as if the district had "Agreed."

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Informal Review (Step 12)

- Upon receipt of a district's informal review request, HHSC will review the documents submitted and will determine the appropriate course of action.
- The agency will contact the district with its determination.
- Once HHSC completes its informal review, the district will be required to submit new Preparer and Entity Certifications forms.

(Informal Review) Appeal Process

If a district does not agree with the informal review decision made by the HHSC Provider Finance Department, the district has an option to appeal through the HHSC appeal process. Formal appeals are conducted in accordance with the provisions of Chapter 357, Subchapter I of the Texas Administrative Code (related to Hearings under the Administrative Procedure Act). Written requests for a formal appeal from the interested party must be received within 15 calendar days after the interested party receives the written decision. Requests must be sent directly to:

HHSC Appeals Division

Mail Code W-613

P.O. Box 149030

Austin, TX 78714-9030

This written request for a formal appeal must state the basis of the appeal of the adverse action and include a legible copy of the written decision from the informal review. The formal appeal is limited to issues that were considered in the informal review process. See TAC Rule §355.110 for additional appeal details and information.

Cost Report Corrections

Corrections may be made up to 60 days after the original due date of the cost report. To make a correction to a cost report:

- Scan and send a written, district-initiated correction request to providerfinanceshars@hhs.texas.gov.
- Correction requests must be on district letterhead and signed by the Financial Contact.
- Correction requests must be notarized.
- Requests should include:
  - District Name
  - District NPI and TPI
  - Year of the cost report in need of correction
  - Brief description of the issue/correction
  - Length of time needed to complete the revisions

Please note, cost reports that are made available for corrections will require new signed and notarized certification forms. Official signature and notary dates must be no earlier than the electronic cost report re-submission date.

STAIRS System Edits

- STAIRS is designed to perform various edit checks on the data entered by cost report preparers.
- Explanation of variances is required.
- When prompted, provide a clear and concise explanation as to why a cost increased, decreased, etc.
- System edits find possible errors and allow ISDs to correct the current financial report before certifying their data.

SHARS Oversight

TEA and HHSC jointly provide oversight to the SHARS program. As part of the joint effort to manage and evaluate the SHARS program, both agencies conduct desk reviews/audits to verify program compliance. These audits/reviews consist of the following:

- Inspector General (IG) Acute Care Surveillance (ACS) Surveillance and Utilization Reviews (SURs)
- TEA desk reviews/audits of IEP documentation
- HHSC Provider Finance Department desk reviews on SHARS cost reports
- HHSC Cost Report Review Unit (CRRU) audit reviews

SHARS Oversight

SUR Desk Review

- Section 456.23 of Title 42, Code of Federal Regulations states that agencies are required to have a post-payment review process that allows State personnel to develop and review: (1) recipient utilization profiles, (2) provider service profiles, (3) exception criteria, and (4) identifies exceptions so that the agency can correct mis-utilization practices of recipients and providers.

- In Texas, the IG ACS unit is responsible for identifying inappropriate payments in the state's Medicaid programs. When conducting retrospective reviews of SHARS provider records, the IG ACS unit applies policy in effect at the time of the service to determine appropriateness of payment. The billing provider is notified via a certified letter of the outcome of the review.

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SHARS Oversight

SUR Desk Review

- The IG ACS unit utilizes a variety of tools to conduct post-payment review activities including the CMS approved Surveillance Utilization Review system application (SURS Profiler +).
- IG ACS works in conjunction with TMHP clinical specialists to evaluate a sample of the provider's documentation to verify all Texas Medicaid Provider Procedure Manual (TMPPM) requirements have been met, including:
  - Billing Requirements,
  - Provider qualifications, and
  - Supporting information such as medical necessity, completeness of records, physician prescription for certain services, required IEP documentation, etc…
- Providers are recouped for any paid services that are determined to be non-compliant with all program requirements.

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SHARS Oversight

SUR Desk Review

For proper adjudication of appeals associated with SURS desk review actions send the applicable correspondence to the following address:

Texas Medicaid & Healthcare Partnership SUR Provider Review Assistant – Aracely Dominguez

MC A11 SUR

12357 – B Riata Trace Parkway, Suite 100

Austin, TX 78727-6524

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SHARS Oversight

Common SHARS Desk Review/Audit Review Findings

- Documentation does not support services rendered.
- Documentation does not include billable time.
- Documentation does not include session notes, start and stop times, total minutes, activity performed, student observation, or related IEP objective.
- Amount of time billed does not match amount of time documented.
- Student was absent on the date of service billed.
- Medical records requested were not submitted.
- Documentation does not support costs reported on cost report (IEP ratio, one-way trip ratio, time study, etc.).

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SHARS Documentation

SHARS records need to be retained for at least *seven years* as they are considered both educational and Medicaid records. At minimum the following documents must be maintained for each SHARS student:

- Eligibility/assessment records
- IEP/ARD documents
- Prescriptions, evaluations, and/or referral information for related services, as appropriate
- Provider qualifications, including licensure/certification records
- Session notes/service logs
- PCS documentation
- Delegated nursing services documentation
- Specialized transportation documentation (daily trip/maintenance logs)
- Attendance records
- Time study participant list
- Parental notice/consent records
- Written agreements/contracts
- Supervision logs
- Claims submittal and payment histories
- Cost report documentation (invoices, salary information, time study documentation, etc.)

SHARS Documentation

For SHARS purposes, the ARD/IEP/Supplement forms should include the following:

- Type (name) of service
- Time, frequency, and duration of service
- Medical necessity
- Medical condition related to service
- Rationale/reason for service
- Goals/objectives for service (e.g., OT, PT) and/or description of service with detailed activities (e.g. PCS, nursing services)
- Parental notice and consent records
- Medicaid number on each page of ARD

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Services requiring session notes:

- Audiology
- Counseling Services
- Occupational Therapy
- Physical Therapy
- Psychological Services
- Speech Therapy

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Session notes must include:

- Student's Medicaid number on each page
- Reference to medical necessity; IEP objective
- Date of service
- Time session begins/ends
- Total billable minutes
- Number of units
- Specifics of the service provided (individual or in a group setting)
- Notation as to activity performed
- Student observation
- Signature/initials

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Shared Services Arrangement (SSA)/Cooperative (Co-op)

- Providers who are members of a cooperative or shared services arrangement must each submit a separate SHARS cost report.
  - Each ISD must have a district specific RMTS participant list (PL) that includes "contracted staff" employed by the fiscal agent and district employees for which costs will be claimed.
  - Failure to maintain a complete district specific PL limits the allowable costs that a district is able to claim on the cost report.
- Allocation methodologies used to distribute shared costs to member districts of a SSA/Co-Op must be documented and presented to HHSC upon request.
  - SSA/Co-Op employees are to be recorded in the cost report as employees by the SSA/Co-Op fiscal agent. If these individuals provide services at the other member districts of the SSA/Co-Op, the member districts should record their portion of the costs as contractor costs.
  - Any worker that only works for an ISD should be reported as an employee on the ISD's cost report.
- Allocation methodologies should appropriately reflect the level of direct service costs associated with the students enrolled in each district.

Shared Services Arrangement (SSA)/Cooperative (Co-op)

The fiscal agent of a SSA or Co-Op can only report costs for the students "enrolled" in the district serving as the fiscal agent. All "shared" costs must be allocated to each of the member districts.

Determination of "enrolled" per the TEA…

"While it is true that multiple districts may be involved in the provision of special education and related services to a student with disabilities, only one district can report Public Education Information Management System (PEIMS) data on a student, so it is our position that the SHARS-related billing should be through the district that is reporting the PEIMS data."

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SHARS Financial Contact Responsibilities

- Oversight, monitoring, and coordination with the RMTS Coordinator to ensure the quarterly participant list data is accurate and appropriate for inclusion of cost on the cost report.
- Must verify that financial data submitted is true and accurate, and that appropriate documentation is maintained to support the time study (i.e., participant training) and cost report.
- Ensure all supporting documentation appropriately identifies the certified funds used for claiming is maintained.
- Ensure the district cooperates with state and federal audits.

SHARS Financial Contact Responsibilities

- Review the findings made by HHSC/TEA;
- Evaluate the client files currently assigned to the district's provider(s);
- Determine if the documentation is appropriate for all Medicaid services delivered by the district's provider(s); and
- Determine if cost is allowable on the cost report.

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Provider vs. Vendor Responsibility

Provider Responsibility	Vendor Support
Outcome of any audit (CAP, recoupments, etc.)	Cost Report Preparation Assistance
Ensure informed parental consent	Additional SHARS training
Train service providers (session notes/logs, parental consent, etc.)	Billing assistance
Agree/Disagree to settlement amount	
Verify cost report accuracy	
Communication with SHARS rate analysts	
Ensure all documentation is provided to HHSC Rate Analysis when requested	

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Polling Questions

Wrap Up

- Training session participants not listed in STAIRS as a SHARS financial contact will not receive credit for completing SHARS Cost Report training.
- Any primary contact at the district can add new SHARS contacts in STAIRS.
- There are no certificates for training.
- Emails will be sent thanking those who attend a training session; however, this does not necessarily mean that training credit will be awarded to all session participants.
- Training credits can be viewed in STAIRS.
- Users MUST filter appropriately to view their training credits.
- Contacts are encouraged to print training credit screens for their records.
- Please allow a maximum of 9 business days processing time for training credit information to be updated and uploaded to STAIRS.
- Once full access is indicated, contacts will be able to build and submit their district's 2020 SHARS Cost Report.

HHSC SHARS Website

The HHSC-SHARS website contains:

- General & Related Information
- Contacts
- Enrollment & Participation
- Frequently Asked Questions
- Guides/Manuals
- Methodology/Rules
- Notices
- Payment Rate Information
- Cost Reporting Information
- Time Study
- Training

https://rad.hhs.texas.gov/acute-care/school-health-and-related-services-shars

Additional Resources…

- CMS Medicaid School-Based Administrative Claiming Guide
- 2 C.F.R. Part 200, Subparts E and F
- Title 45 Code of Federal Regulation (CFR) Part 74 and 95
- Title 42 CFR 430.1 and 42 CFR 431.15
- Title 19 of the Social Security Act, section 1903(a)(7)
- Title 1 of the Texas Administrative Code, Part 15, Chapter 354, SubChapter A, Division 25, Rules 1341-1342

  http://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=5&ti=1&pt=15&ch=354&sch=A&div=25&rl=Y
- Title 1 of the Texas Administrative Code, Part 15, Chapter 355, SubChapter J, Division 23, Rule 8443

  http://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=1&pt=15&ch=355&rl=8443
- General information regarding Texas Medicaid Program

  https://hhs.texas.gov/services/health/medicaid-chip

Reference Materials

Texas Education Agency website:

- https://tea.texas.gov/index2.aspx?id=25769817836

Texas Medicaid & Healthcare Partnership

- http://www.tmhp.com/Pages/Medicaid/Medicaid_home.aspx

Texas Medicaid Provider Procedures Manual

- http://www.tmhp.com/Pages/Medicaid/Medicaid_Publications_Provider_manual.aspx

SHARS Contacts

SHARS Cost Reports & SHARS Interim Rates:

Phone: (512) 730-7400

Email: ra_shars@hhsc.state.tx.us

SHARS Program/Policy/Certification of Funds/Billing/Payment Questions:

Phone: (512) 462-6278

Email: HHSC_Oversight@hhsc.state.tx.us

SHARS Cost Report System Questions:

Fairbanks Hotline: (888) 321-1225

Email: info@fairbanksllc.com

TEA – Division of Fiscal Compliance:

Angela Foote (SHARS Coordinator)

Phone: (512) 463-6639

Email: angela.foote@tea.texas.gov

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Thank you